STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING _____ B. WING _____	C 12/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	200 GREEN MEADOWS DR GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the investigation of complaint IN00099831. Complaint IN00099831 unsubstantiated due to lack of evidence. This visit was done in conjunction with the Post Survey Revisit [PSR] to the Recertification and State Licensure survey. This visit included the PSR to the investigation of complaint IN00098276 completed on 11-4-11. Survey dates: December 3, 6, & 7, 2011 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Survey team: Angel Tomlinson RN TC Sharon Lasher RN Census bed type: SNF/NF: 138 Total: 138 Census payor type: Medicare: 16 Medicaid: 81 Other: 41 Total: 138 Sample: 3 Kindred Transitional Care was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING _____ B. WING _____	C 12/07/2011

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F 000	Continued From page 1 Complaint IN00099831. Quality review completed 12/9/11 Cathy Emswiller RN	F 000		